Regional Medical Evacuation & Patient Tracking MUTUAL AID PLAN (MAP)

Scott Aronson, MS

Russell Phillips & Associates, LLC
Fire and Emergency Management for Healthcare Facilities

www.phillipsllc.com

Public Health
Seattle & King County

TODAY'S GOALS

8:30 AM – 10:30 AM

- Project Background & Timeline/Actions
- Critical Plan Elements
- Barriers to Implementation

You Must Be Ready Internally

- Incident Command System (HICS/HEICS/ICS)
- Full Building Evacuation Plan
  - Get the patient to the sidewalk
- Census Reduction / Surge Capacity Plan
- Influx of Patients Plan
  - Not an MCI
    - Acuity and significant diagnosis is a known entity

Plan Timeline

Task Force / Special Expertise Groups

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Comment Period

May – June 2008

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Executive Briefing

June 2008

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2nd Comment Period

August 2008

→ **Data Collection – KCHealthTrac**

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Task Force Final Approval

September 2008

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Training / Tabletop

October 22, 2008

PLAN OVERVIEW

Subscribing Organizations

- King County Hospitals

Vendor MOU

- EMS / Fire
- Suppliers – Pharma, Med-Surg, etc.
- City OEM
- Public Health of Seattle & King County

OVERVIEW

- Assist each other during a disaster
- Provide a clear and concise activation process
- Place and support care of evacuated patients
- Provide staff, supplies, and equipment (so you don't have to evacuate)
  - For a Disaster Struck Hospital (evacuation)
  - For a Patient Accepting Hospital (evacuation)
  - For a Disaster Struck Hospital (isolation)
- Provide transportation resources

RESPONSIBILITIES OF MEMBERS

- Number (range) and Type of Patients
  - Type: What are you qualified to care for
  - Capacity: Assume 100% Occupancy
- Implement Internal Disaster Notification
  - Activation of Command Center at Hospital
- Attendance/Participation at Meetings and Drills
- Documentation: Patient Evacuation Tracking Form and Patient / Medical Record and Equipment Tracking Sheet

RESPONSIBILITIES OF MEMBERS

- Any additional Washington DoH Requirements – ultimate regulatory authority
- Like to like evacuation:
  - Level of Acuity
    - Variable: Staff and equipment going with patient
- MAP to compliment RDP, ESF 8 and Region 6 Hospital Preparedness Plan
- Intent of MAP to ultimately link other Washington Regions, adjacent states and BC

Regional Medical Evacuation and Patient Tracking
Mutual Aid Plan (MAP)

Regional Medical Evacuation and Patient Tracking
Mutual Aid Plan (MAP)

ALGORITHMS

- OVERVIEW
- PLAN OBJECTIVE
- SCOPE & RESPONSIBILITIES OF PLAN MEMBERS

MEMORANDUM OF UNDERSTANDING

- PATIENT PLACEMENT (Phase I – VI)
- CAPACITY (At Member Facilities)

PLAN COMMUNICATION

TRANSPORTATION OF PATIENTS

- MEDICAL RECORDS & MEDICATIONS (Going With Patient)
- PATIENT IDENTIFICATION

Tracking
Mutual Aid Plan (MAP)

TRANSPORTATION OF PATIENTS

- MEDICAL RECORDS & MEDICATIONS (Going With Patient)
- PATIENT IDENTIFICATION
- PATIENT TRACKING

STAFF, PHARMACEUTICALS, SUPPLIES AND EQUIPMENT (In Need Of and Transportation Of)

ATTACHMENT A
PATIENT EVACUATION TRACKING FORM

ATTACHMENT B
PLAN MEMBERS

ATTACHMENT C
VENDORS MEMORANDUM OF UNDERSTANDING

ATTACHMENT D
SUMMARY OF HOSPITAL-SPECIFIC INFORMATION

ALGORITHM

- Facility and Region
  - Resource Requirements – Avoid Evacuation
  - Phase I – III Evacuation
  - Phase IV – VI Evacuation

RESOURCE REQUIREMENTS – TO AVOID EVACUATION

Individual Facility in Need of Resources

Individual health care facility being affected:

1. Notify appropriate Emergency Agency (911 or non-emergency number) and ensure the City/Town Emergency Manager is aware of the incident.
2. Implement internal disaster notification. Establish internal disaster plan and Command Center - **required** if requesting assistance
3. Notify Public Health Duty Officer (206-296-4606) - Health & Medical Area Command (HM Area Command) will call the Washington State DoH for the Disaster Struck Facility[ies] if necessary.
4. If not already done, HM Area Command will utilize KCHealthTrac to put all King County healthcare facilities and critical partners on alert.
5. If necessary, the HM Area Command will notify City of Seattle or County Office of Emergency Management to request State Mission #
6. Continue to follow your facility's internal Emergency Management / Emergency Operations Plan and send a representative to the local EOC to assist in resource coordination and communications.

Medical Needs

HM AREA COMMAND

Work through the HM Area Command for all medical needs. This includes staff, supplies, pharmaceuticals, medical equipment, Strategic National Stockpile (SNS) requests, and blood distribution

- HM Area Command will work with other organizations via phone, fax, e-mail and KCHealthTrac to identify available resources.

Non-medical Needs

LOCAL EMERGENCY OPERATIONS CENTER (EOC)

Work through the local EOC for all non-medical needs. This includes generators, HVAC units, transportation (i.e. Buses), etc..

- In the event the local EOC is unable to assist the facility, work through the King County ECC.
- If additional assistance is needed, inform the HM Area Command of the situation and seek resource support.

NEED SUPPLIES AND EQUIPMENT

1. Call your facility's suppliers.
2. Work with the HM Area Command to secure suppliers or staff listed in the

NEED TRANSPORTATION FOR INCOMING SUPPLIES:

1. Work with the local EOC to secure transportation resources.

NEED STAFF

1. Call your facility's staffing personnel vendors (i.e. Nurse relief teams, staffing agencies.)

NEED SUPPLIES AND EQUIPMENT

1. Call your facility's suppliers.
2. Work with the HM Area Command to secure suppliers or staff listed in the Mutual Aid Plan (MAP) from Vendors.
3. Work with the local Emergency Operations Center (EOC) to address other supplies and equipment requests.
4. See supply and equipment availability from member facilities within your MAP.

NOTES:

1. Fax request form to supplier to use as identification at police roadblocks.

NEED TRANSPORTATION FOR INCOMING SUPPLIES:

1. Work with the local EOC to secure transportation resources.
2. If the local area is overwhelmed by the complexity or magnitude of the disaster, all requests will be coordinated through the HM Area Command. HM Area Command will in turn work with ESF 5 (Emergency Management) to coordinate resources.
   a. Transportation help may be secured from facilities within your Mutual Aid Plan (MAP) for box trucks or other transportation vehicles that may be available.
   b. Request may be filled from outside of King County based on the magnitude of the incident.

NEED STAFF

1. Call your facility's staffing personnel vendors (i.e. Nurse relief teams, staffing agencies.)
2. Work with the HM Area Command to secure staff listed in the Mutual Aid Plan (MAP) from other member facilities via the Medical Reserve Corp (MRC.)
3. Work with the local EOC to address non-medical staff (i.e. damage assessment team, food service support, etc.)

NOTES:

1. Fax request form to other facilities to use as identification for staff at police roadblocks. If from another healthcare facility, ensure they have their facility ID and one other form of acceptable identification.

Legend

EOC – Emergency Operations Center
EMS – Emergency Medical Services
HM Area Command – Health and Medical Area Command
KC ECC – King County Emergency Coordination Center
MAP – Mutual Aid Plan
NDMS – National Disaster Medical System

REGIONAL ACTIONS: Phase I – III Evacuation

DISASTER OCCURS FORCING EVACUATION – PATIENT LIFE SAFETY IS PRIORITY

ACTIVATION / NOTIFICATION

Disaster Struck Facility:

1. Call 911, notifying appropriate local emergency responders.
2. Implement internal disaster notification. Establish internal disaster plan and Command Center - **required** if requesting assistance.
3. Notify Hospital Control (HC) to prepare for Patient Evacuation
   Harborview ED phone: 206-744-4074; ED Charge Nurse phone: 206-731-4025; or 800 MHz on hospital common channel
   Back up - Overlake ED: 425-462-5100
4. Assigns a Liaison Officer to communicate with HC & Health & Medical (HM) Area Command re: patient placement and transportation needs
5. Assigns a Liaison Officer to report to the local EOC to assist in resource coordination and communications (if applicable)
6. Continue to follow your facility's internal Emergency Management / Emergency Operations Plan

Hospital Control (HC):

- Notify Public Health Duty Officer (206-296-4606)

Health & Medical (HM) Area Command:

1. Activated by the Public Health Duty Officer
2. Verifies the local Emergency Manager / Municipality is aware of the incident
3. Notifies the Washington State DoH for the Evacuating Facility[ies]
4. Requests a State Mission number through the City of Seattle / County Office of Emergency Management.
5. Confirms KCHealthTrac used to alert King County healthcare facilities and critical partners.

TRANSPORTATION FOR EVACUEES

1. Fire / EMS provide on-site transportation for patients
2. HC and HM Area Command coordinate patient placement.

If additional non-EMS transportation resources are needed and requests escalate above the capacity of local EOC:

3. Evacuating Facility notifies HM Area Command
4. HM Area Command requests assistance from KC ECC to mobilize transit agencies and private transportation contractors who are members of the Regional Disaster Plan

EVACUATION ACTIONS

Disaster Struck Facility:

- Establishes Unified Command with local / on-site Emergency Response Agencies.
- Implements census reduction / discharge plan to minimize number of patient transfers
- Send Patient Medical Record/Chart and tracking forms (and staff, as necessary)
- Track patients and staff with Patient Evacuation Tracking Form
- Evaluate the necessity of transferring controlled substances with patients.
- Disaster Struck Facility notifies each patient's responsible party and physician (utilizing Regional Call Center if facility is overwhelmed.)

Hospital Control:

- Coordinates patient movement to Patient Accepting Facilities including the number and type of patients being sent (see Patient Transportation.)
- Slow evacuation: Distributes patients based on bed availability

placement.

If additional non-EMS transportation resources are needed and requests escalate above the capacity of local EOC:

3. Evacuating Facility notifies HM Area Command
4. HM Area Command requests assistance from KC ECC to mobilize transit agencies and private transportation contractors who are members of the Regional Disaster Plan.
5. HM Area Command requests assistance from state EOC via KC ECC.
6. State assistance may trigger activation of mutual aid between adjacent states (Emergency Management Assistance Compact) or federal assets.

- transfers
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Hospital Control:

- Coordinates patient movement to Patient Accepting Facilities including the number and type of patients being sent (see Patient Transportation.)
- Slow evacuation: Distributes patients based on bed availability
- Fast evacuation: Distributes patients based on pre-planned range for number and type of patients for accepting facilities

HM Area Command:

- Considers activation of Medical Needs Shelter for patients qualified for discharge.
- Activate Regional Call Center if Disaster Struck Facility is overwhelmed.
- Assures notification of other healthcare facilities in the region.
- Alerts the State of Washington DOH or State EOC to notify facilities outside King County

Legend

EOC – Emergency Operations Center
EMS – Emergency Medical Services
HC – Hospital Control
HM Area Command - Health & Medical Area Command
KC ECC – King County Emergency Coordination Center
MAP – Mutual Aid Plan

MULTIPLE FACILITY EVACUATION

HM Area Command (utilizing Hospital Control):

- Assign patients to Patient Accepting Facilities.
- Establish Area Command to ensure that EOCs and the KC ECC are coordinating to manage the incident.
- Consider activation of an Alternate Care Facility (ACF)

ACTIVATION PHASES I – III

Phase I: First 2 – 4 hours for current Open Staffed Beds / Census Reduction.

Phase II: Up to 24 hours using full Surge Capacity Plan with Staffed Beds.

Phase III: Up to 24 hours for overflow areas where staff and equipment from other facilities are required to ensure continuity of care. Long-term care (skilled nursing) facilities may be considered in Phase III for lower acuity patients.

PATIENT ACCEPTING FACILITY

1. Activate internal plans to receive evacuated patients
   a. Identify patient intake areas and communicate to Hospital Control
   b. Consider initiating Surge Capacity Plan
   c. Consider initiating Census Reduction Plan
2. Assume provision of all staff and equipment required for evacuated patients until Disaster Struck Facility's staff and equipment arrive.
3. Notify Disaster Struck Facility or Regional Call Center when patients have been received.
4. Admit the patient and assign an attending physician.
5. Start a new Medical Record / Chart for the patient and clearly delineate the end point in the existing Medical Record / Chart.

REGIONAL ACTIONS – Phase IV – VI Evacuation

Phase I – III Incapable of Handling Patient Volume in Region 6

REGIONAL EVACUATION:

Health & Medical Area Command (HM Area Command):

1. In conjunction with KC ECC and/or the Seattle EOC will be in communication with Washington State DoH and State EOC.
2. Advise if the Emergency Management Assistance Compact (EMAC) should be activated between states for additional EMS units and emergency staff.
3. Follow activation protocol for appropriate Federal Agencies (i.e. NDMS) to provide resource coordination for regional evacuation.

Hospital Control

1. Continue to coordinate patient movement until outside area Emergency Agencies assume command.

Phase IV Activation: Regional Beds/EMAC

PRIORITY EVACUATION REGIONS (see Patient Placement):

1. Region 5
2. Region 1
3. Region 2
4. Region 3
5. Greater Portland, OR area
6. Region 9

Phase V Activation: Alternate Care Facilities

ALTERNATE CARE FACILITIES (ACF)

Activated through HM Area Command:

- Estimated time for ACF to be at a level ready to receive patients: 12 – 24 hours.
- Assumption: includes staff from Disaster Struck Facility being transported to ACF with the patient (coordinated through the Volunteer Management System – VMS.)
- Transportation of Supplies, Pharmaceuticals and Equipment: responsibility of the HM Area Command working with the appropriate EOC or KC ECC

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Phase VI Activation: Federal Resources

Department of Health & Human Services (DHHS)

DHHS works with the State EOC to coordinate initial response, then with HM Area Command for two objectives:

- Priority 1: Insert teams to support the ability to sustain patient care in the Region
- Priority 2 (if Priority 1 fails):Utilize the NDMS Activation and Request Protocol to secure federal assets
  - Federal contracts for ground and air transport
  - Federal medical facilities

If air evacuation protocols are utilized, pick-up points would be at Sea-Tac, Boeing Field and Paine Field

Legend

EOC – Emergency Operations Center
EMS – Emergency Medical Services
HM Area Command – Health and Medical Area Command
KC ECC – King County Emergency Coordination Center
MAP – Mutual Aid Plan
NDMS – National Disaster Medical System

Section 4: Patient Placement

- Phase I: First 2-4 hours – Open Staffed Beds / Census Reduction
  - Disaster Struck Facility:
    - Implement Census Reduction Plan
    - Prepare patients for discharge or move to Medical Needs Shelters when possible to reduce evacuees
- Phase II: 12 – 24 Hours Surge Capacity – Open Staffed beds / Surge Capacity Plan
- Phase III: Open Spaces – Staff by Disaster Struck facility or Disaster Staffing Plan

Section 4: Patient Placement

- Phase IV: Adjacent Regions
  - Order of Priority: Region 5 (Pierce County), Region 1, Region 2 (Kitsap County Area/Bremerton), Region 3 (Thurston County Area/Olympia), Greater Portland, Region 9
    - AirLift Northwest Evacuation Support
- Phase V: Alternate Care Facilities
  - May activate in Phase III: 12 – 24 hours to establish
- Phase VI: Federal Resource
  - Priority 1: Insert teams to support care
  - Priority 2: Utilize NDMS activation for ground and air assets / Federal medical facilities
  - Pick-up Points include: Sea-Tac, Boeing Field and Paine Field (McChord AFB for out of Region movement if accessible)

Section 4: Actions of Disaster Struck Facility

- Communication with Hospital Control (with EMS/Fire)
  - Number of patients to be transferred
  - Levels of Care necessary
  - Specialized services requested (i.e. burn patient, etc.)
- KCHealthTrac for Hospital Bed Capacity by Level of Care
- Documentation:
  - Medical Record including Medical Administration Record (MAR) sent if possible
  - Patient Evacuation Tracking Form
  - Patient, MR and Equipment Tracking Sheet

Section 4: Actions of Patient Accepting Facilities

- Patient under care of Patient Receiving Facility
  - Assigned Admitting Physician until discharged, transferred or reassigned
  - Patients may be returned to the Disaster Struck Facility (not likely)
  - Absolute Exceptions:
    - Discharged to home or alternate level of care
    - Patient/family/responsible party refuses transfer
    - Attending physician deems patient unstable for transport
- Communicate receipt of patient with the Regional Call Center (if active) or the Disaster Struck Facility (if necessary)

Section 4: Communication with Families/Resp Party/PMD

- If Disaster Struck Facility is unable to accomplish this:
  - Regional Call Center
    - Broadcast via television, radio, hospital operators, recorded messages and websites to communicate with Families/Staff/Community
    - Staffed support, when possible, from Disaster Struck Facility staff

FACILITY NAME
HOSPITAL PATIENT CAPACITY

Type of Hospital Patient	**Peak Capacity Staffed Bed Capacity**	**1st Phase – Number of Patients** (Estimate range of staffed beds which can be created in 2-4 hours)	**2nd Phase – Staffed Beds Created in 12-24 Hours** (activation of full Surge Capacity Plan)	**3rd Phase – Number of Patients Which Can Be Accepted in Overflow** (Space within the hospital that may not be outfitted with equipment or staff) – Clinical staff may move in with patients
Bariatric (>400lbs)				
Burn				
Burn ICU				
Dialysis Beds - Inpatient				
ICU - Adult (Charlie II)				
ICU - Neonatal				
ICU - Pediatric				
Labor, Delivery & Post Partum				
Med/Surg – Adult (Charlie I)				
Med/Surg – Pediatric				

ICU - Adult (Charlie II)				
ICU - Neonatal				
ICU - Pediatric				
Labor, Delivery & Post Partum				
Med/Surg – Adult (Charlie I)				
Med/Surg – Pediatric (Charlie IV)				
Psychiatric – Adult Locked (Involuntary)				
Psychiatric – Adult Locked (Voluntary)				
Psychiatric – Peds Locked (Involuntary)				
Psychiatric – Peds Locked (Voluntary)				
Transplant Patients				
Other Beds Not Listed				
TOTAL BEDS				

Section 5: Communications

- Protocol:
  - Disaster Struck Facility
    - 911 or local non-emergency number
    - Internal Activation / Activation of Hospital Command Center
    - Hospital Control (Immediate Life Threat) or Public Health Duty Officer (Resources or Extended Disaster)
  - Health & Medical (HM) Area Command will communicate with:
    - State DoH
    - KCHealthTrac to notify all other Region 6 healthcare facilities of disaster
    - City of Seattle or County OEM to request State Mission #

Section 5: Communications

- Plan references Region 6 Hospital Emergency Preparedness Plan
  - Sample of updates to plan on next page

Section 6: Transportation

- Disaster Struck Facility will provide:
  - Total requiring Critical Care Transport (i.e. Ventilator, NICU)
  - Total requiring Isolation for Infectious Disease
  - Total requiring bariatric transport (Non-ambulatory and >400lbs.)
  - Total requiring ALS Transport
  - Total requiring BLS Transport
  - Total Wheelchair Van/Bus Patients - Transfer to another healthcare facility (Note if alternate level of care is possible and which level required – i.e. Skilled Nursing)
  - Total for Standard Ground Transport – Transfer to another healthcare facility (Note if alternate level of care is possible and which level required – i.e. Skilled Nursing)
  - Discharge to Home:
    - Total Wheelchair Van/Bus Patients
    - Total for Standard Ground Transport

Plan includes reviewing all non-traditional EMS transports including buses with multi-liter capability.

Categorization of Patients for Evacuation: Charge Nurse Criteria

a. Patients requiring Critical Care Transportation (RN-staffed or Advanced-trained Paramedic)

- IVs with medications running that exceed paramedic capabilities
- IV pump(s) operating (can be provided by the transport crew)
- Need any medications administered via Physician orders by any means in any dosage prescribed
- Cardiac monitoring/pacing (can be provided by the transport crew – external pacing only is crew provided) / intra-aortic counterpulsation device / LVAD
- Ventilator dependent (vent can be provided by the transport crew)
- Pediatric patients requiring ECMO
- Neurosurgical ventricular drains
- Invasive hemodynamic monitoring which cannot be temporarily or permanently discontinued (i.e. intra-arterial catheter if noninvasive blood pressure have not been reliable for patient, they are hemodynamically unstable, and they have a continuing chance of survival)

b. Patients requiring ALS transport (Paramedic)

- IVs with medication running that are within paramedic protocols (varies by county)
- IV pump(s) operating
- Need limited medications administered via Physician orders by limited means in limited dosage prescribed
- Cardiac monitoring/pacing (can be provided by the transport crew – external pacing only is crew provided)
- Ventilator dependent with own or facility ventilator
- Prone or supine on stretcher required

c. Patients requiring BLS transport (EMT)

- Oxygen therapy via nasal cannula or mask (can be provided by the transport crew)
- Basic maintenance IVF including TPN (total parenteral nutrition)
- IVs with clear fluids (no medications)
- Visual monitoring / Vitals (BP/P/Resp)
- Prone or supine on stretcher required or unable to sustain
- If Behavioral Health, please provide this information

c. Patients requiring BLS transport (EMT)

- Oxygen therapy via nasal cannula or mask (can be provided by the transport crew)
- Basic maintenance IVF including TPN (total parenteral nutrition)
- IVs with clear fluids (no medications)
- Visual monitoring / Vitals (BP/P/Resp)
- Prone or supine on stretcher required or unable to sustain
- If Behavioral Health, please provide this information

d. Patients requiring Chair Car/Wheelchair Accessible Bus (No medical training)

- No medical care or monitoring needed, unless the patient has their own trained caregiver in attendance capable of rendering the care
- Not prone or supine, no stretcher needed
- No oxygen needed, unless patient has own prescribed portable oxygen unit that can be safely secured enroute.

NOTE: Some wheelchair van companies provide a standard wheelchair, if needed, for the duration of the trip. Buses do not provide wheelchairs. Some electric wheelchairs cannot be secured in wheelchair vans due to size or design. These are NOT be transported with the patient.

e. Patients requiring normal means of transport (any vehicle - No medical training)

- No medical care or monitoring needed, unless the patient has their own trained caregiver in attendance capable of rendering the care
- No oxygen needed, unless patient has own prescribed portable oxygen unit that can be safely secured enroute.
- Not prone, supine, or in need of a wheelchair (can ambulate well enough to climb bus steps)

NOTE: A person with a folding wheelchair, who can ambulate enough to get in and out of a car, could go by car if there was room to bring/pack the wheelchair.

f. Patients requiring bariatric ambulance or transport (>400lbs.)

Section 6: Transportation

- Special Considerations (higher impact facilities):
  - VA - ICU
  - Overlake - ICU
  - UWMC – ICU / NICU
  - NAVOS Inpatient/West Seattle Psych
  - Harborview
  - Swedish First Hill – ICU / Bariatric / NICU
  - Regional - Vents
  - Children's – Peds/NICU
  - Northwest – Psych
  - Fairfax - Psych

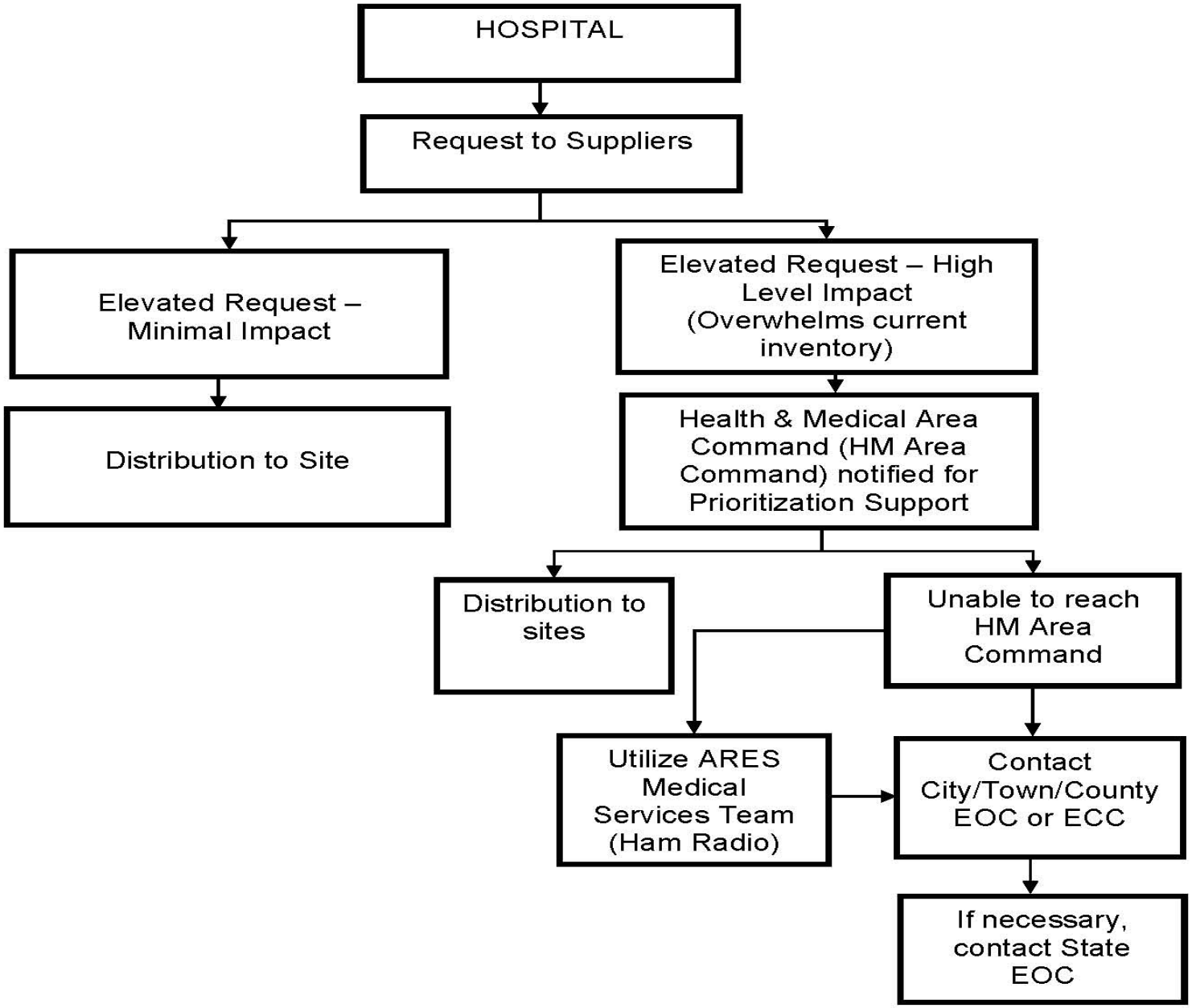
Section 7: Records, Meds, Identification/Tracking

- Patient Evacuation Tracking Form
- Medical Record including MAR/Face Sheet
  - New Chart started at Patient Receiving Facility
- Medications and Controlled Substances
- Wristband (or permanent marker)
  - Name
  - DOB or MR# (if applicable)
  - Code Status (if currently on wristbands)
- Patient/Medical Record and Equipment Tracking Sheet
- Medication Transfer Form

Section 8: Staff, Pharmaceuticals, Supplies, Equipment

- KCHealthTrac for Management of
- Coordinated through Health & Medical Area Command for Medical
  - Non-medical coordinated with Local EOC, Seattle EOC or King County ECC

SUPPLIERS


HOSPITAL
Request to Suppliers
Elevated Request – Minimal Impact
Distribution to Site
Elevated Request – High Level Impact (Overwhelms current inventory)
Health & Medical Area Command (HM Area Command) notified for Prioritization Support
Distribution to sites
Unable to reach HM Area Command
Utilize ARES Medical Services Team (Ham Radio)
Contact City/Town/County EOC or ECC
If necessary, contact State EOC

Section 8: Staff, Pharmaceuticals, Supplies, Equipment

- Staff (new discussion)
  - Supervisory
    - Overseen by Disaster Struck Facility
  - Back-fill Support (you are isolated/in need)

Section 8: Staff, Pharmaceuticals, Supplies, Equipment

- Supplies / Equipment
  - Request to Standard Vendors 1st
    - Verbal first followed by documentation if possible
  - Supplies Listed in MAP 2nd
  - Other facilities in Region 6 3rd
    - Pharmaceuticals from member hospital

MEMORANDUM OF UNDERSTANDING

- Purpose of Plan
- Definition
- General Principles of Understanding
- Care of Patients - Responsibility
- Voluntary Commitments

Data Collection from Hospitals - Ensure Plan Success

- Internal / External Communications
- Patient Capacity
  - 2-4 hours (Census Reduction)
  - 12-24 hours staffed beds (Surge)
  - 12-24 hours open space (Catastrophic)
- Supplies / Equipment
- Transportation Vehicles
  - Including LTC Support